



Halfmoon Township

Board of Supervisors
Mark J. Stevenson, Chairman
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Barbara H. Spencer, Supervisor
Todd Kirsten, Supervisor

100 Municipal Lane
Port Matilda, PA 16870
(814)692-9800
Fax (814) 692-7585

Susan Steele
Manager

TO: Interested Insurance Carriers

**RE: Request For Group Vision Insurance Proposals
RFP 2012-002
Halfmoon Township, PA**

February 1, 2012

Insurance Carriers:

I am writing to your company on behalf of Halfmoon Township, PA, hereinafter referred to as the "Planholder", requesting that you prepare a proposal reflecting your charges for group vision insurance. We have not reviewed our present vision plan with Vision Benefits of America in some time and therefore to ascertain if the Township is receiving comparable benefits at a comparable price, we are in the process of reviewing our current vision plan.

Halfmoon Township employs 4 full time employees, one part time, 6 elected officials, and around 25 seasonal employees. Only the fulltime employees and supervisors are eligible to participate in the Township's vision plan. Currently all four full time employees participate in the Township's present vision plan. The Township presently pays the entire cost of the vision premium for the **full time employee only**.

Submission of Proposals: Three (3) copies of all proposal documents, exhibits and answers to specific questions shall be sealed and submitted no later than June 16, 2012, at 4:00 p. m. to:

**Susan Steele, Township Manager
Halfmoon Township
100 Municipal Lane
Port Matilda, PA 16870**

MARK ENVELOPE: "RFP NO. 2012-002 VISION INSURANCE"

Late proposals will not be accepted.

Selection: Recognizing the fact that there are very important considerations involved in selecting an insurance carrier, the Planholder is not bound to accept the lowest proposal. The Planholder reserves the right to reject any or all proposals or to accept any proposal deemed advantageous to the Planholder. The award of the contract shall be made to the responsible offerer whose proposal is determined to be relatively priced, offerers' vision care providers accepting said plan against what providers' the present employees are using, comparable benefits, and other evaluation factors set forth in the Request for Proposals. Proposals will be evaluated based on the following criteria and in the following order (with #1 being the most important):

1. Will employees need to change present vision care providers if Township changes to new provider?
2. Offerer's benefits and deductibles
3. Offerer's ease of claim transmission and payment
4. Offerer's gross premium
5. Offerer's availability of local providers, specialists, and facilities
6. Offerer's qualifications/experience
7. Offerer's support/services provided

8. Offerer's retention charges
9. Offerer's other municipal or public clientele

Please complete and return the enclosed forms, which include: Proposal form including declaration of compliance, questionnaire and references.

Upon submittal, the proposals will be reviewed at the staff level. The top three Offerers will be contacted by the Township Manager and be asked to conduct two presentations. One to the staff and one to the Board of Supervisors to address any questions either entity may have. The Township Manager will review both elected official and staff comments as well as proposals and then make a recommendation to the Board of Supervisors. The Board of Supervisors shall have the right to approve the Manager's recommendation, table the recommendation, or approve a different Offerer.

PLAN ADMINISTRATION QUALIFICATIONS

Planholder Responsibility

The Planholder will provide for payment of the premiums, and payroll deductions if any, for premiums and advise the carrier of additions/deletions from the coverage. The Planholder will assist in the logistics of the enrollment process.

Selected Carrier Responsibility

The carrier will provide claim instructions, forms, employee identification cards, employee booklets outlining the benefits and instructions on filing a claim electronically or in written form, enrollment and orientation materials, and other appropriate communication materials deemed necessary by the Planholder as well as provide a Policyholder staff member, if requested by Planholder, to orient and address employee questions.

GENERAL INFORMATION AND INSTRUCTIONS

1. All proposals must be received at the designated location by the deadline shown. Proposals received after the deadline shall be considered void and unacceptable. Halfmoon Township is not responsible for non-delivery of mail, carrier, etc.
2. Proposals are anticipated to provide a 12 month rate guarantee, with a contract period of September 26, 2012 through September 25, 2013, and three optional 12 month periods beginning September 26, 2013 and extending through September 25, 2016. However, the Planholder reserves the right to accept a guarantee of less than or more than 12 months if it is in the Planholder's interest. Premium rates proposed must be firm and not subject to change based upon enrollment.
3. The Planholder reserves the right to reject any and all proposals and to accept any proposal deemed advantageous to the Planholder. Since there are important considerations involved in selecting a carrier, in addition to rates, the Planholder will not be required to accept the lowest proposal. In addition to cost, service will also serve as a basis for award of the contract.
4. The Carrier must submit evidence of ability to service the group without undue requirements of the Planholder's employees. Each Carrier should list as references municipal or public entity groups that is services in the State of Pennsylvania.
5. Your proposal must conform in all respects to the specifications outlined in this letter and attached exhibits. If your company's practice prohibits you from submitting a proposal on the same basis as outlined in the specifications, you may submit a proposal on a basis that is in accordance with your practice. Please state clearly, in detail, any deviation from the specifications outlined in this letter with complete reference to the provision from which the deviation is being made.
6. Proposals must be based on benefits similar to the current plan however all options for vision coverage will be considered. (Plan of current benefits provided). The current plan with Vision Benefits of America is through an agent, a proposal submitted to provide vision benefits may be through an agent or directly with a provider.
7. HIPAA Compliance with Privacy and Confidentiality guidelines will be required.
8. Proposals shall include coverage on all eligible full time employees and Board of Supervisors and with optional coverage available for dependent coverage. Fulltime is defined as 40 hours or more per week. Dependent is defined as the employees' or supervisors' spouse and/or children from birth to age 26. Adopted children, stepchild(ren) or foster child(ren) who are in a legal parent-child relationship are also classified as eligible dependents. Children who

are currently disabled will be covered as long as they are totally disabled and dependent upon the support from their parents.

9. Waiting period: Newly hired employees and their dependents must complete at least a 90 day waiting period before becoming eligible for coverage.
10. Currently the employer pays 100% of the employee premium for the coverage for FULL TIME EMPLOYEES ONLY, 0% of the dependent premium for any plan coverage. There is no retiree coverage. The employer currently pays 0% of the supervisors premium.
11. Please complete the appropriate enclosed proposal forms.
12. The Township does not need to provide a five year claim history due to the number of employees under PA law.

ATTACHMENTS:

Attachment A is the form to provide your information.

Attachment B is the form for your insurance costs quotation

Attachment C is the form to provide a comparison of the plan benefits submitted in the proposal to provide a comparison to current plans.

Attachment D is the form to provide information on references

In preparing your premium quotations, please use the forms provided.

We look forward to receiving your proposal. This letter provides you with the information necessary for you to submit a proposal, which includes complete and carefully prepared information for consideration by the Planholder.

If you have any questions, please direct all inquiries to: Susan Steele, Township Manager, Halfmoon Township, 100 Municipal Lane, Port Matilda, PA 16870, via email to manager@halfmoontwp.us prior to June 2, 2012.

Sincerely,

Susan E. Steele
Township Manager
Halfmoon Township

ATTACHMENT A
VENDOR INFORMATION

Name of Organization: _____

Date Founded: _____

Name of Contract Person: _____

Title: _____

Phone Number: _____

Address: _____

Email: _____

Fax Number: _____

ATTACHMENT B

PROPOSAL FORM

The undersigned, does hereby declare that they have read the specifications for Group Vision for the Planholder employees, and with full knowledge of the requirements, does hereby agree to furnish the administrative services in full accordance with the specifications and requirements. The undersigned also agrees to duplicate present coverage and if not, will attach itemized detail of any differences.

Please provide monthly vision care costs in the table below.

	Proposed Plan 1	Proposed Plan 2	Proposed Plan 3
Employee/Supervisor only			
Employee/Supervisor and spouse			
Employee/Supervisor and children			
Employee/Supervisor and family			

Vision Plan Carrier: _____

Address: _____

Printed Name: _____

Signature: _____

Title: _____ Date: _____

ATTACHMENT C

PLAN DESIGN/PROPOSED PLAN

PLAN DESIGN	PRESENT PLAN	PROPOSED PLAN (In/Out Network)
Vision Exam	One every 24 months	
Lenses	One every 24 months	
Frames	One every 24 months	
Vision Exam	100% in-network	
Single Vision	100% in network	
Bifocal, Trivocal, Lenticular	100% in network	
Progressive	Controlled Cost	
1 year scratch protection	100% in network	
Contacts (in lieu of glasses)	\$160.00	
Medical or surgical treatment of eye	NOT COVERED	
PREMIUMS		
Employee Only:	\$5.76 per month	
Employee & Spouse	\$11.00 per month	
Employee & Children	\$11.00 per month	
Employee & Family	\$11.00 per month	

ATTACHMENT D

REFERENCES

Company Name: _____

Contract Person: _____ **Title:** _____

Address: _____

City: _____ **State** _____ **Zip** _____

Phone number: _____ **email:** _____

Company Name: _____

Contract Person: _____ **Title:** _____

Address: _____

City: _____ **State** _____ **Zip** _____

Phone number: _____ **email:** _____

Company Name: _____

Contract Person: _____ **Title:** _____

Address: _____

City: _____ **State** _____ **Zip** _____

Phone number: _____ **email:** _____

Company Name: _____

Contract Person: _____ **Title:** _____

Address: _____

City: _____ **State** _____ **Zip** _____

Phone number: _____ **email:** _____

